NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case Name : _____
Number : _____
Worker Name : _____
Number : _____
Telephone: _____
Address : _____
_____
_____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells you how. Your benefits may not be changed if you ask for a hearing before this action takes place.

_____ , as of _____, we are lowering your cash aid from $_____ to $_____. Cash aid will stop for you, the family's second parent.

We are lowering your cash aid because you did not have a good reason for not doing what you agreed to do in the compliance plan that you signed. You agreed to: _____
_____

We will not pay for transportation, or work- or training-related expenses while you are off cash aid. We may pay for child care, if you work or attend school.

HOW TO GET BACK ON CASH AID

You can get back on cash aid if you are eligible for it by:

☐ Contacting the county and telling them you want your cash aid back; then doing what the county asks.

☐ Contacting the county no earlier than 45 days before _____, and telling them you want your cash aid back; then doing what the county asks. Even if you do this, your cash aid will not be restored earlier than_____.

TO CONTACT THE COUNTY ABOUT GETTING BACK ON CASH AID, CALL _____

The family's other parent, _____, may also get cash aid again if he/she is eligible for it by:

☐ Contacting the county and telling them he/she wants cash aid back; then doing what the county asks.

☐ Contacting the county no earlier than 45 days before _____, and telling them he/she wants cash aid back; then doing what the county asks. Even if he/she does this, cash aid will not be restored earlier than _____ .

DO YOU NEED FREE LEGAL HELP? You can get free help with this problem from:

Local Legal Aid Office: ( )

_____

State Welfare Rights Organization: ( )

_____

Food Stamps: If the failure to meet Welfare to Work requirements also causes a food stamps penalty, you may not be able to get food stamps for at least 1, 3 or 6 months. If there is a food stamps penalty, you will get another notice telling you how long your food stamps will be stopped.
Medi-Cal: This Notice of Action does NOT change or stop Medi-Cal benefits. **Keep your plastic Benefits Identification Card(s).**
Rules: These rules apply. CalWORKs MPP § 42-712 (exemptions); 42-713 (good cause); 42-721 (noncompliance and good cause). Food Stamps MPP § 63-407.521. You may review these rules at your welfare office.

Your New Monthly Cash Aid Amount Is Figured Below

Section A. Countable Income, Month of _____

Total Business Income	$	
Business Expenses:		
a. 40% Standard	-	
OR		
b. Actual	-	
Net Earnings from Self-Employment	=	
Total Disability-Based Unearned Income of (Assistance Unit + Non-Assistance Unit Members)	$	
$225 Disregard	-	
Nonexempt Unearned Disability-Based Income	=	
OR		
Unused Amount of $225 Disregard	=	
Total Earned Income	$	
Net Earnings from Self-Employment (from above)	+	
Subtotal	=	
Unused Amount of $225 Disregard (from above)	-	
Subtotal	=	
Earned Income Disregard 50%	-	
Subtotal	=	
Nonexempt Unearned Disability-Based Income (from above)	+	
Other Nonexempt Income of (Assistance Unit + Non-Assistance Unit Members)_____	+	
Net Countable Income	=	

Section B. Your Cash Aid, Month of _____

1.	Maximum Aid _____ Persons (Assistance Unit + Non-Assistance Unit Members)	$	
2.	Special Needs (Assistance Unit only)	+	
3.	Net Countable Income from Section A	-	
4.	Subtotal	=	
5.	Maximum Aid _____ Persons (Assistance Unit only) (Excluding Sanctioned Persons)	$	
6.	Special Needs (Assistance Unit only)	+	
7.	Maximum Aid Subtotal	=	
8.	**Full Month Aid Subtotal** (Lowest Amount on Line 4 or 7	=	
9.	Line 8 Prorated for Part of Month	=	
10.	Adjustments: 25% Child Support Sanction	-	
	Overpayment	-	
	Other Sanctions	-	
	Bonus	+	
11.	**Monthly Cash Aid Amount** (Line 8 or 9 Adjusted)	=	

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, Food Stamps, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, Food Stamps or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ Food Stamps ☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

OR

- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE